

See reverse side of certificate before issuing  
certified copies. 3/13/58 - MB

HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Worton, RFD</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Worton, RFD</b>			
c. LENGTH OF STAY IN 1b <b>Lifetime</b>				d. STREET ADDRESS <b>****</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>****</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Edward</b> Last <b>Blackston</b>				4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 16, 1882</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>57</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Washington Blackston</b>			
14. MOTHER'S MAIDEN NAME <b>Nellie Carroll</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>218-16-5879</b>			
16. SOCIAL SECURITY NO. <b>218-16-5879</b>				17. INFORMANT <b>Lewin Blackston, RFD 1, Worton</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>?</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>hypertension</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 2</b> , 19 <b>57</b> , to <b>Nov. 7</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Oct. 7</b> , 19 <b>57</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Worton</b> DATE SIGNED <b>Nov. 7, 1957</b>							
ACTUAL SIGNATURE <b>Florence D. Joyce</b> M.D. <b>Worton</b>				PHYSICIAN'S NAME (Type) <b>Florence D. Joyce, M. D.</b> <b>Worton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Worton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Victor N. Kennedy, Still Pond, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>11/10/57</b>		24b. REGISTRAR'S SIGNATURE <b>E. Kennard Jones</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Film #0226 - 3/13/58 - Mq

The original certificate was lost. We could not get Dr. Joyce to send us a signed replacement certificate, so we copied the information from the pink copy obtained from the Kent County Hlth. Dept. The signature of Dr. Joyce was traced from the pink copy.

*Flora H. Joyce*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12006									
Item 18 Film 222 11-25-57 ams										11999									
CERTIFICATE OF DEATH										Reg. Dist. No. 202									
1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kennedyville</b>					c. LENGTH OF STAY IN 1b <b>Life</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kennedyville</b>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kennedyville</b>					d. STREET ADDRESS <b>1</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <b>KATIE V.</b> Middle <b>CREW</b> Last					4. DATE OF DEATH Month <b>Nov</b> Day <b>10</b> Year <b>1957</b>														
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 21 1879</b>		9. AGE (In years last birthday) yrs. <b>78</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>					11. BIRTHPLACE (State or foreign country) <b>Kent Co. Md.</b>					12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>John P. VanDyke</b>					14. MOTHER'S MAIDEN NAME <b>Anna Hayes</b>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>---</b>					17. INFORMANT <b>C. Howell Crew</b> Address <b>Chestertown, Md.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.9</b> DUE TO <b>internal</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer of Esophagus</b> (c) <b>Heart Disease</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>Sept 1, 1957</b> , to <b>Nov 10, 1957</b> , that I last saw the deceased alive on <b>Nov 10th, 1957</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.																			
ACTUAL SIGNATURE <b>L. P. Atwell</b>					ADDRESS (Street, city or town, state) <b>Steel Pond Md.</b>					DATE SIGNED									
PHYSICIAN'S NAME (Type) <b>L. P. Atwell</b>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>					22b. DATE THEREOF <b>Nov. 13/57</b>					22c. NAME OF CEMETERY OR CREMATORY <b>Chester</b>					22d. LOCATION (City, town, or county) (State) <b>Chestertown, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marvin A. Williams</b> ADDRESS <b>Chestertown, Md.</b>										24a. REC'D BY REGISTRAR <b>Nov 13-57</b>					24b. REGISTRAR'S SIGNATURE <b>Clara Baines</b>				

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES EARL RAY		35		M		W		1928		MEMPHIS		TENNESSEE		U.S.A.				4/4/68		MEMPHIS		TENNESSEE		U.S.A.			
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE									
CAUSE OF DEATH		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
MANNER OF DEATH		NATURAL		ACCIDENT		HOMICIDE		SUICIDE		OTHER																	
DISEASE OR INJURY		GUNSHOT WOUND		HEART DISEASE		CANCER		TUBERCULOSIS		DIABETES		HYPERTENSION		ASTHMA		EPILEPSY		PSYCHIC DISORDER									
SYMPTOMS		BLOODSTAIN		FINGERPRINT		TOOTH MARK		HAIR MARK		SKIN MARK		BONE MARK		OTHER MARK													
TESTS		X-RAY		AUTOPSY		TOXICOLOGY		BLOOD TEST		URINE TEST		OTHER TEST															
FINDINGS		GUNSHOT WOUND		HEART DISEASE		CANCER		TUBERCULOSIS		DIABETES		HYPERTENSION		ASTHMA		EPILEPSY		PSYCHIC DISORDER									
TREATMENT		SURGERY		MEDICATION		PHYSIOLOGY		OTHER TREATMENT																			
HISTORICAL DATA		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
FAMILY HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
SOCIAL HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
OCCUPATIONAL HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
EDUCATIONAL HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
MILITARY HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
RELIGIOUS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
LEGAL HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
FINANCIAL HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
PSYCHOLOGICAL HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
PHYSICAL HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
MENTAL HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
SUBSTANCE ABUSE HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
SEXUAL HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
IMMUNIZATION HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
VACCINATION HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
TRANSFUSION HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
ORGAN TRANSPLANT HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
GENETIC HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
ENVIRONMENTAL HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
LIFESTYLE HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
DIETARY HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
EXERCISE HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
SLEEP HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
STRESS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
MORALITY HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
ETHICS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
RELIGIOUS BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
POLITICAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
CULTURAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
SOCIAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
ECONOMIC BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
TECHNOLOGICAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
ENVIRONMENTAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
LIFESTYLE BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
DIETARY BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
EXERCISE BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
SLEEP BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
STRESS BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
MORALITY BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
ETHICS BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
RELIGIOUS BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
POLITICAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
CULTURAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
SOCIAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
ECONOMIC BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
TECHNOLOGICAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
ENVIRONMENTAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
LIFESTYLE BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
DIETARY BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
EXERCISE BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
SLEEP BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
STRESS BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
MORALITY BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
ETHICS BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
RELIGIOUS BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
POLITICAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
CULTURAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
SOCIAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
ECONOMIC BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
TECHNOLOGICAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
ENVIRONMENTAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
LIFESTYLE BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
DIETARY BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
EXERCISE BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
SLEEP BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
STRESS BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
MORALITY BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
ETHICS BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
RELIGIOUS BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
POLITICAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															
CULTURAL BELIEFS HISTORY		MURDER		SUICIDE		NATURAL CAUSE		ACCIDENT		HOMICIDE		OTHER															

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12000

## CERTIFICATE OF DEATH

12007  
200

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>KENT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>KENT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GALENA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GALENA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>W.</b> Middle <b>JOHNS</b> Last		4. DATE OF DEATH <b>Nov.</b> Month <b>9</b> Day <b>1957</b> Year	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 24, 1864</b>
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>BENJAMIN P. WALTERS</b>		14. MOTHER'S MAIDEN NAME <b>MARY P. VANSANT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>NICHOLAS WALTERS, STILL POND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>AS Cardiovascular disease with cardiac enlargement and failure</b> DUE TO <b>Probable uremia and terminal broncho pneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>pneumonia</b> (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 or 3 years one week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 9, 1957</b> to <b>Nov. 9, 1957</b> , that I last saw the deceased alive on <b>Nov. 9, 1957</b> , and that death occurred at <b>12:15 PM</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)		DATE SIGNED <b>11/12/57</b>	
ACTUAL SIGNATURE <b>Robert W. Farr, M.D.</b>		M.D. <b>Chestertown, Md.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11/13/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GALENA CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>GALENA, KENT CO. MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward H. Halloway, Mellington, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov 18 1957</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Ely Melford</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

12001

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lenora</u> First <u>Virginia</u> Middle <u>McClary</u> Last				4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1957</u>			
5. SEX <u>Fem</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 3, 1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cambridge, Mt. U.S.A.</u>	
13. FATHER'S NAME <u>Stephen Smith</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>216-10-2028</u>		17. INFORMANT <u>William McClary</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Infarction, Myocarditis</u> DUE TO (c) <u>Hypertension Arterio Sclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 1957, to <u>Nov 2</u> , 1957, that I last saw the deceased alive on <u>Nov 1</u> , 1957, and that death occurred at <u>2 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Norbert C. Nitsch</u> M.D.				ADDRESS (Street, city or town, state) <u>Rock Hall</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>NORBERT C. NITSCH</u>				<u>ROCK HALL MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/5/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar E. Lane</u>				ADDRESS <u>Church Hill Rd</u>		24a. REC'D BY REGISTRAR DATE <u>11/5/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>S. Wood</u>			

NOV 13 1957

RECEIVED



## 12002 CERTIFICATE OF DEATH

Reg. Dist. No. 263

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>Marie</u> Last <u>Mercer</u>		4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/25/1957</u>
9. AGE (In years lost birthday) <u>6</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas H. Mercer</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice Ann Gessner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Beatrice Ann Gessner</u>		Address <u>Rock Hall, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute enteritis</u> 571.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Diet</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 31</u> , 1957, to <u>Nov 1</u> , 1957, that I last saw the deceased alive on <u>Nov 1</u> , 1957, and that death occurred at <u>4:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Kester</u>		ADDRESS (Street, city or town, state) <u>Rock Hall</u> M.D. <u>Nov 2</u> DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/3/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar E. Lane</u>		24a. REC'D BY REGISTRAR DATE <u>11/3/57</u>	
ADDRESS <u>Church Hill, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Silvestre Angers</u>	

2022232XV3

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

BUREAU V. R.

NOV 13 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11997

## CERTIFICATE OF DEATH

1201

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>KENT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESTERTOWN</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENNEDYVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KENT &amp; QUEEN ANNE'S HOSP.</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>T.</u> Middle <u>EARL</u> Last <u>NICKERSON</u>			4. DATE OF DEATH Month <u>NOV</u> Day <u>10</u> Year <u>1957</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 15, 1886</u>		9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer (owner)</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DAVID NICKERSON</u>				14. MOTHER'S MAIDEN NAME <u>IDA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNK.</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NO</u>		17. INFORMANT <u>HOSPITAL RECORD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>2nd HYPERTENSION.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>POSTOPERATIVE STATE: PROSTATECTOMY, BENIGN.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. <u>3</u> p. m. 19 <u>57</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>OCT 29, 1957</u> , to <u>NOV 10</u> , 1957, that I last saw the deceased alive on <u>NOV 9</u> , 1957, and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. T. KEEFE, JR.</u>				M.D. <u>CHESTERTOWN, Md.</u>		DATE SIGNED <u>NOV 10, 57</u>	
PHYSICIAN'S NAME (Type) <u>A. T. KEEFE, JR. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 13, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Kennedyville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Kennedyville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u>				ADDRESS <u>Md. Chestertown,</u>		24a. REC'D BY REGISTRAR <u>NOV 13 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clara Barnes</u>			

# MARYLAND STATE DEPARTMENT OF HEALTH - BATHING

## CERTIFICATE OF DEATH

BUREAU V. 3

NOV 13 1957

RECEIVED

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED	

# BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11998

## CERTIFICATE OF DEATH

12012

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Kent</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>				c. LENGTH OF STAY IN 1b <b>13 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kenr &amp; Queen Annes</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Lena</b> First Middle Last <b>E Robinson</b>			4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>1957</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1913</b>		9. AGE (In years last birthday) <b>44</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Hiram Wallace</b>				14. MOTHER'S MAIDEN NAME <b>Delia Simmons</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-24 0910</b>		17. INFORMANT <b>Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cirrhosis of Liver</b> <b>581.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. <b>11</b> p. m. Month, Day, Year <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>November 15, 1957</b> to <b>November 28, 1957</b> , that I last saw the deceased alive on <b>Nov 28, 1957</b> , and that death occurred at <b>7:30A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert W. Farr</b>				ADDRESS (Street, city or town, state) <b>Chestertown, Md.</b> DATE SIGNED <b>11/28/57</b>			
PHYSICIAN'S NAME (Type) <b>Robert W. Farr</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. I, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fountain Cem. (col)</b>		22d. LOCATION (City, town, or county) (State) <b>Worton, Md. RFD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Herbert W. Waller</b>				ADDRESS <b>Chestertown, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 2 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Class Barnes</b>			



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED			
JAMES EARL RAY		Male		35		White		April 22, 1928		Memphis, Tennessee		April 4, 1968		Memphis, Tennessee		4:15 PM		Shot		Suicide		[Signature]		[Signature]		[Signature]		[Signature]			
16. OCCUPATION		17. EDUCATION		18. MARITAL STATUS		19. RELIGION		20. PREVIOUS ILLNESS		21. PREVIOUS SURGERY		22. PREVIOUS TRAUMA		23. PREVIOUS DRUGS		24. PREVIOUS ALCOHOL		25. PREVIOUS TOBACCO		26. PREVIOUS OTHER		27. PREVIOUS OTHER		28. PREVIOUS OTHER		29. PREVIOUS OTHER		30. PREVIOUS OTHER			
Attorney		High School		Married		Methodist		None		None		None		None		None		None		None		None		None		None		None			
21. I certify that I attended the deceased from the time of death until the time of signing this certificate.		22. I certify that I am a duly qualified physician and surgeon in the State of Tennessee.		23. I certify that I am a duly qualified registrar in the State of Tennessee.		24. I certify that I am a duly qualified witness in the State of Tennessee.		25. I certify that I am a duly qualified witness in the State of Tennessee.		26. I certify that I am a duly qualified witness in the State of Tennessee.		27. I certify that I am a duly qualified witness in the State of Tennessee.		28. I certify that I am a duly qualified witness in the State of Tennessee.		29. I certify that I am a duly qualified witness in the State of Tennessee.		30. I certify that I am a duly qualified witness in the State of Tennessee.		31. I certify that I am a duly qualified witness in the State of Tennessee.		32. I certify that I am a duly qualified witness in the State of Tennessee.		33. I certify that I am a duly qualified witness in the State of Tennessee.		34. I certify that I am a duly qualified witness in the State of Tennessee.		35. I certify that I am a duly qualified witness in the State of Tennessee.		36. I certify that I am a duly qualified witness in the State of Tennessee.	

RECEIVED  
DEC 2 1967  
BUREAU V. 3